



**COLORADO DEPARTMENT OF  
HEALTH CARE POLICY AND FINANCING  
MEDICAL ASSISTANCE PROGRAM**

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**MEDICAID COST REPORT INSTRUCTIONS FOR  
FREESTANDING FEDERALLY QUALIFIED HEALTH CENTERS**

**EFFECTIVE DATE  
JANUARY 1, 2016**

In circumstances where the State of Colorado rules are revised subsequent to this effective date, the rules adopted by the State of Colorado will supersede the guidance in this manual.

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## INTRODUCTION

### **Medical Assistance Programs and Federally Qualified Health Centers**

Medicaid is a program in which the Federal government grants funding to states, including the State of Colorado, for the purpose of providing medical assistance programs on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services (Section 1901 of the Social Security Act).

“Federally Qualified Health Center” (FQHC) means an entity which is a recipient of a grant under Section 330 of the Public Health Service Act (Section 1905 (1) (2) (B) of the Social Security Act). The State of Colorado contracts with FQHCs to provide medical services to patients who are determined to be Medicaid beneficiaries. A FQHC can be either hospital-based or freestanding; this manual pertains to the latter. To ensure that federal Public Health Service Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries, the State of Colorado is required to make payment for FQHC services at 100% of the costs which are reasonable and related to the cost of furnishing medical services.

FQHC costs must be related to medical services provided and must be allowable, allocable, reasonable and given consistent treatment in the accounting records. Medical services that may be provided include general services for outpatient primary care, emergency services, and services provided through agreements or arrangements, such as inpatient hospital care, physician services, or additional and specialized diagnostic and laboratory services not available at the FQHC (10 CCR 2505-10 8.700.3). Allowable costs include compensation of provider staff, costs of services and supplies related to services delivered by provider staff, overhead costs and costs of services purchased by the FQHC (10 CCR 2505-10 8.700.5.A). Unallowable costs include, but are not limited to, expenses that are incurred by a FQHC and that are not for the provision of covered services, according to the laws, rules, and standards applicable to the Medical Assistance Program in Colorado. A FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per-visit encounter rate for Medicaid clients (10 CCR 2505-10 8.700.5.B).

### **General Cost Reporting Principles**

In preparing the cost report and billing Medicaid, FQHCs should follow these overarching principles:

- Allowable costs are those that are reasonable and associated with providing services that are defined in Colorado’s Medicaid State Plan, in the FQHC’s HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#).
  - Allowable costs include those directly or indirectly tied to patient care, and those related to increasing access for the target patient population or informing them of available services.
  - Unallowable costs include those for unallowable advertising and marketing activities, those associated with fundraising, and those for staff performing those functions. For clarification on allowable and unallowable advertising and marketing costs, see the [Medicare Provider Reimbursement Manual, Part 1](#), Chapter 21, Section 2136.

- All allowable costs are included in the cost report, unless the FQHC has chosen to bill certain incident to services outside of the encounter rate on a fee-for-service basis.
  - If the FQHC has chosen to bill for the incident to service at the fee-for-service rate, the associated costs must be removed from the cost report.
  - If a service's costs are included in the final reported costs used to calculate the encounter rate, the FQHC may not bill Medicaid fee-for-service for those costs.
- Medicaid only pays for services once (i.e. if a FQHC receives a Medicaid grant for Medicaid client services, that revenue would be removed from the cost report.)
- Only visits with qualified, allowable FQHC providers can be billed as an encounter.
- Only one-on-one, face-to-face visits can be billed as an encounter. Group sessions cannot be billed as an encounter for any FQHC services. However, the cost of group sessions may be included in the cost report.
- Services with no associated costs in the cost report should not have associated visits.

## **Reimbursement and Rate Calculation**

FQHCs shall be reimbursed a per-visit encounter rate based on 100% of reasonable cost. A FQHC may be reimbursed for up to three separate encounters occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: medical encounter, dental encounter or behavioral health encounter. Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited unless it is a distinct behavioral health encounter, which is allowable only when rendered services are covered and paid by a contracted Behavioral Health Organization (BHO) (10 CCR 2505-10 8.700.6.A). BHOs may allow billing and pay for a broader set of providers than the State. The FQHC should reference its written BHO contracts for this determination.

“Visit” means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker. Group sessions do not generate a billable encounter for any FQHC services (10 CCR 2505-10 8.700.1). Costs for services delivered by these providers are included as covered health care costs in the cost report and the related visits cannot be billed in any other manner than via the annually established encounter rate. There may be Medicaid-covered services that are delivered by a provider not listed above. If so, these visits may be billed on a fee-for-service basis, with the costs not included in the cost report (e.g. physical therapy), or may remain in the cost report as incident to services which do not produce a billable encounter.

After the cost report has been finalized, the auditor/contractor, along with the Department of Health Care Policy and Financing, will calculate the new Prospective Payment System (PPS) and Alternative Payment Method (APM) rates. Effective July 1, 2014, the encounter rate shall be the higher of the PPS rate or the APM rate. The APM rate shall be the lower of the annual rate or the base rate. The annual rate shall be the FQHC's current year calculated inflated rate, after audit. The base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index (MEI) to

coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years. (See Appendix B for examples of the rate calculation and rebasing forms).

Final approval of the cost report is communicated to the FQHC in writing and includes the final approved encounter rate, effective date, outstationing reimbursement data, description of the appeal process and the detail of the FQHC base rate, APM rate, and PPS rate calculations. The new encounter rate shall be effective 120 days after the FQHC's fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120<sup>th</sup> day after the FQHC's fiscal year end (10 CCR 2505-10 8.700.6.C).

## **Who Must File**

This manual contains the instructions for completing the Medicaid Cost Report for freestanding FQHC facilities in the State of Colorado. In order to maintain compliance with the program, all FQHCs participating in the Medicaid Program must file a cost report annually. Newly designated FQHCs shall file a preliminary estimated cost report. Data from the preliminary cost report, as well as rates established for FQHCs in the same or adjacent area with a similar caseload, shall be used to set a reimbursement base rate for the first year.

## **Filing Due Dates**

The cost report must be filed with the cost report auditor/contractor no later than 90 days after the end of the FQHC's fiscal year. An extension of up to 60 days may be granted based upon circumstances; however, the FQHC must contact the auditor/contractor prior to the due date to request an extension. A properly filed extension request will not delay the encounter rate effective date. Failure to submit a cost report within 180 days after the end of the fiscal year shall result in suspension of payments.

## **Cost Report Forms**

Current Medicaid cost report forms will be distributed to FQHCs in January of each year. (See Appendix A for a complete set of forms). Use the line numbers and cost center descriptions exactly as formatted on the preprinted form. Do not change these lines or descriptions. If additional or different cost centers are needed, use the blank lines on the form and label them clearly. If additional space is needed, enter the total of several cost center expenses on a blank line and provide the detail as an attachment. Indicate N/A on forms the FQHC does not need, and do not exclude these forms from the cost report submission.

In order to maintain Medicaid program compliance, each FQHC must file a complete cost report package including the following forms:

- Statistical Data/Certification Form
- Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses
- Worksheet 1 – Supplement 1 – Reclassifications

- Worksheet 1 – Supplement 2 – Adjustments to Expenses
- Worksheet 2 – Provider Staff, Visits and Productivity
- Worksheet 3 – Determination of Overhead and Encounter Rate
- Addendum 1 – Encounter Report
- Addendum 2 – Unallowable Expenses
- Workpaper A – Medicaid Outstationing Activity
- Workpaper B – Medicaid Outstationing Salary/FTE Information

The following documents must be submitted with the FQHC cost report:

- Audited Financial Statements
- Working Trial Balance with Crosswalk (see example in Appendix C)
- Detailed breakdown of all expenses reported as “other” or “miscellaneous”
- Physician contracts or agreements, if requested by auditor/contractor
- Full Time Equivalents (FTE) report by department for all staff of the FQHC (see example in Appendix C)

Submitted cost report forms must reflect the same fiscal period as the audited financial statements. Total expenses on the cost report must reconcile with the FQHC’s audited financial statements. All costs must be reported on the accrual basis and only costs for the reporting period must be used; no costs from other periods are allowable.

**All of the cost report forms must be completed. Each form should be accurate, completed according to instructions, and in as much detail as possible. The prescribed forms must be used by each FQHC. No substitute forms will be accepted.**

Please note that many cells in the forms contain formulas established for correct calculations. Do not change these formulas. The description of each formula is typically described in detail so that the figure resulting from the formula can be verified by the cost report preparer.

## **Rounding**

Use the following rounding standards for fractional computations:

- Round to 2 decimal places
  - Rates
  - Cost per visit
- Round to 6 decimal places
  - Ratios
  - Limit adjustments

**Report all other numbers (worksheet columns) as whole numbers – do not report cents in dollar figures.**

## **Submission of the Cost Report**

The cost report may be filed electronically via email or by regular mail. If filed via email, a scanned copy of the signed Statistical Data/Certification form must be emailed or faxed.

Electronic submissions can be sent to:

- [eglenn@mslc.com](mailto:eglenn@mslc.com) or
- [mcapelle@mslc.com](mailto:mcapelle@mslc.com)

Paper submissions can be sent to:

Myers and Stauffer, LC  
6312 S. Fiddlers Green Circle, Suite 510N  
Greenwood Village, CO 80111  
303-694-3605

## **Maintenance of Records**

All accounting, financial, medical and other relevant records of the FQHC must be maintained for a minimum of six years following the date of the filing of the cost report.

## **Appeals**

A FQHC has thirty (30) days from the mailing date of the rate notification letter to file a written appeal, pursuant to 10 C.C.R 2505-10, Section 8.050.3.A. Appeals should be addressed to:

Jennifer Weaver  
First Assistant Attorney General  
Department of Law, Health Care Unit  
Ralph L. Carr Colorado Judicial Center  
1300 Broadway, 6<sup>th</sup> Floor  
Denver, CO 80203

Zabrina Iris Perry  
FQHC Rates Analyst  
Fee-for-Service Rates Section  
Department of Health Care Policy and Financing  
1570 Grant Street  
Denver, CO 80203

## STATISTICAL DATA/CERTIFICATION FORM

The Statistical Data/Certification form collects data on the FQHC. Complete each line as follows:

**Line 1** - Report the date the cost report is being submitted. Report the full legal name and address of the FQHC, including phone and fax numbers and the email address for the cost report main contact person. The “Date Received” should be left blank and will be completed by the cost report auditor/contractor.

**Line 2** - Report the assigned FQHC facility number for each site operated by the FQHC. If there are more facility sites than lines, this data may be reported on a separate schedule (Tab 2) of the Statistical Data/Certification Form. FQHCs should prepare and submit one cost report for all sites combined.

**Line 3** - Report the beginning date and end date of the FQHC reporting period. This should be the FQHC’s fiscal year.

**Line 4** - Report the type of control of the FQHC by entering an X in the appropriate area.

**Line 5** - Report any other entities that are owned by, or related through common ownership or control to, the FQHC submitting the cost report (i.e. other FQHCs, Rural Health Clinics, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Suppliers, etc.).

**Line 6** - Report the type of Federal funding awarded to the reporting FQHC by placing an X next to each source of funding.

**Line 7** - Report the name and individual Medicaid billing number for each provider furnishing services at the FQHC. If there are more providers than lines, this data may be reported on a separate schedule (Tab 2) of the Statistical Data/Certification Form. Providers include the following: physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker.

### **Certification by Officer or Administrator of Clinic**

Report the FQHC legal name and facility number. The cost report must be signed by an officer or administrator of the FQHC authorized by the Board of Directors with signatory authority. The cost report may be filed electronically via email or by regular mail. If filed via email, a scanned copy of the signed Statistical Data/Certification form must be emailed or faxed.



## **WORKSHEET 1 – RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

Worksheet 1 is used to report total costs of the FQHC for the reporting period. Total costs reported on Worksheet 1, Column 5 must agree to the audited financial statements as well as the trial balance generated from the FQHC's accounting system. Unallowable and non-reimbursable costs will be reclassified or adjusted off in Columns 6 and 8. All cost centers listed may not apply to all FQHCs and those lines may be left blank. If additional or different cost centers are needed, use the blank lines on the form and label them clearly. If additional space is needed, enter the total of several cost center expenses on a blank line and provide the detail as an attachment. The FQHC must have reliable documentation to support cost splits between direct and overhead cost. All costs must be reported on the accrual basis and only costs for the reporting period must be used; no costs from other periods are allowable.

Costs for services delivered by State-approved providers are included as covered health care costs in the cost report and the related visits cannot be billed in any other manner than via the annually established encounter rate. There may be Medicaid-covered services that are delivered by a provider not listed in State regulations. If so, these visits may be billed on a fee-for-service basis, with the costs not included in the cost report (e.g. physical therapy).

Some costs of the FQHC are not reimbursed via the encounter rate. These costs are “carved out” of the cost report and, depending upon the type of cost, they are either reimbursed to the FQHC on a fee-for-service basis or via a separate billing number (e.g. pharmacy). Some of these costs will be adjusted out of the cost report (Column 8) and others will be reclassified to the non-reimbursable section of the cost report (Column 6). Examples of such “carved out” services are:

- Services provided to patients on an inpatient basis in a hospital
- Behavioral health services billed to a Behavioral Health Organization (BHO)
- Nexplanon devices
- Gardasil injections
- Flu vaccines administered outside of a provider face-to-face visit
- Pharmacy
- Care exceeding podiatry limits – one standard treatment allowed every 60 days

Some costs are not covered services for a FQHC and must be adjusted out of the cost report in Column 8. Examples of such costs include the following:

- Chiropractic
- Alternative medicine such as acupuncture
- Investigative and experimental treatments
- Ophthalmology
- Circumcision
- Lamaze, birthing and parenting classes
- Infertility treatments
- Spermicide, female condoms, home pregnancy tests

- Sterilization reversal
- Ultrasounds performed only for determination of the sex of the fetus or to provide a keepsake photo
- Three- and four-dimensional ultrasounds
- Paternity testing
- Home tocolytic infusion therapy

As of July 1, 2015, diabetes self-management education is a Medicaid-covered service for a FQHC. However, in order to be reimbursed for these services, the program at the FQHC must be recognized by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE) as a Diabetes Self-Management Education provider. If the program at the FQHC is recognized, the FQHC may include the costs of diabetes self-management education in the cost report, as well as generate an encounter when there is a one-on-one, face-to-face visit with an allowable FQHC provider. Even if the visit does not generate an encounter, the costs may still be included in the cost report and used in the subsequent calculations that determine the FQHC's per-visit encounter rate. If the program at the FQHC is not recognized, the costs for these services must be adjusted out of the cost report in Column 8.

## **Column Descriptions and Instructions**

### **Columns 1 through 5**

Report costs in columns 1 through 5 in accordance with the accounting records of the FQHC as follows:

- **Column 1** – Compensation – cost of salaries and wages paid to FQHC employees.
- **Column 2** – Fringe Benefits – cost of fringe benefits paid on behalf of FQHC employees. It is acceptable for fringe benefits to be pro-rated to cost centers based upon salary figures. Fringe benefits includes FICA, Medicare, health insurance, disability insurance, profit sharing, unemployment, worker's compensation, continuing medical education if specific to medical providers, dues and subscriptions if part of the provider contract, other benefits, etc.
- **Column 3** – Purchased & Contract Services – cost of contracted services paid other than to employees (i.e. locum providers, laboratory, radiology, janitorial, etc.).
- **Column 4** – Other – miscellaneous costs that do not fit into the other columns such as supplies, transportation, etc.
- **Column 5** – Total of Columns 1 through 4.

The total cost in Column 5 must reconcile to the FQHC's audited financial statements for the fiscal year being reported as well as the trial balance generated from the FQHC's accounting system. The FQHC must present a crosswalk from the accounting system-generated trial balance to the lines on Worksheet 1. See Appendix C for an example.

### **Column 6**

Record any reclassifications of expense that are required for proper cost allocation. The cost centers affected should be specifically identifiable and documented in the FQHC's records and/or the cost report workpapers. Reclassifications are necessary when the expenses applicable to more than one of the cost

centers listed on Worksheet 1 are maintained in the FQHC's accounting books and records in one cost center or account. For example, if a physician performs administrative duties, the appropriate portion of his or her compensation, fringe benefits and payroll taxes should be reclassified from Covered Health Care Costs to Overhead Costs. **Note the net total of entries in Column 6 must equal zero on Line D – Total Costs.**

Worksheet 1 – Supplement 1 – Reclassifications is provided to compute and record the reclassifications for proper cost allocation. Detailed instructions regarding reclassifications of expense can be found in that section of the Cost Report Manual.

### **Column 7**

Column 7 should reflect the sum of the entries in Column 5 adjusted (increased or decreased) by the reclassification amounts in Column 6. Column 7, Line D – Total Costs must agree with total of Column 5, Line D – Total Costs. The total cost in Column 5 must reconcile to the FQHC's audited financial statements for the fiscal year being reported as well as the trial balance generated from the FQHC's accounting system. The FQHC must present a crosswalk from the accounting system-generated trial balance to the lines on Worksheet 1. See Appendix C for an example.

### **Column 8**

Record adjustments of expense in Column 8. Adjustments include unallowable costs, services "carved out" and reimbursed on a fee-for-service basis, costs for non-FQHC approved services, etc.

Worksheet 1 – Supplement 2 – Adjustments to Expenses is provided to record adjustments necessary for proper cost allocation. The total of Column 8 should equal the total of the adjustments recorded on Worksheet 1 – Supplement 2 – Adjustments to Expenses. Further instructions regarding adjustments of expense can be found in that section of the Cost Report Manual.

### **Column 9**

Column 9 should reflect the sum of the entries in Column 7 adjusted (increased or decreased) by the amounts in Column 8. These are the final reported costs for the encounter rate calculation.

## **Line Descriptions and Instructions**

### **Section A: Covered Health Care Costs**

These are costs incurred to provide a finished health care product or service including, but not limited to, salaries and benefits of direct health care staff, contractual payments for direct health care, supplies and materials, purchase of equipment under the FQHC capitalization threshold, repair and maintenance of equipment, etc.

**Line 1–Physicians** – Costs incurred for physicians who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work under contract as independent contractors.

If a contract, job description or employment agreement for physicians or other health care staff includes the requirement and guarantee of payment towards continuing education, these costs should be included in Column 2 for the appropriate health care staff.

If the FQHC pays hospital dues or similar costs directly to institutions where health care providers provide care to FQHC clients, these costs should also be included in Column 2 for the appropriate health care staff.

**Line 2–Interns/Residents** – Costs incurred for interns and residents who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work under contract as independent contractors.

**Line 3–Physicians Assistants** – Costs incurred for physician assistants who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 4–Nurse Practitioners** – Costs incurred for nurse practitioners who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 5–Nurse-Midwife** – Costs incurred for nurse-midwives who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 6–Medical Assistants/Nurse Aides** – Costs incurred for medical assistants or nurse aides who are furnishing direct health care services to patients. Report unlicensed nurses on this line.

**Line 7–Other Nurses (RN/LPN)** – Costs incurred for Registered Nurses or Licensed Practical Nurses who are furnishing direct health care services to patients. This line is for reporting licensed nurses.

**Line 8–Podiatrists** – Costs incurred for podiatrists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 9–Dentists** – Costs incurred for dentists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors. Dental laboratory costs and dental supply costs should also be reported on this line.

**Line 10–Dental Assistants** – Costs incurred for dental assistants who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 11–Dental Hygienists** – Costs incurred for dental hygienists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 12–Clinical Social Worker** – Costs incurred for clinical social workers who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors.

**Line 13-Optometry Supplies** – Costs incurred for provision of optometry services to patients, including those who are employed by the FQHC as well as those who work under contract as independent contractors. If costs for optometry services provided by a non-FQHC provider are billed fee-or-service, those costs must be adjusted out of the cost report in Column 8. The FQHC may only bill for an encounter when provided by an Ophthalmologist; all other optometry visits should be excluded from Worksheet 2.

Relative to BHO/non-BHO, FQHCs are allowed to submit a claim to Medicaid for mental health primary diagnoses only if the client was seen at the FQHC by a medical (non-BHO) provider. Visits by a BHO provider should be submitted to the appropriate BHO.

**Line 14-Psychology/Psychiatry-Non-BHO** – Costs incurred for psychology/psychiatry providers who are furnishing direct health care services to patients that are not for a BHO-covered diagnosis.

**Line 15-Psychology/Psychiatry-BHO** – Costs incurred for psychology/psychiatry providers who are furnishing direct health care services to patients that are for a BHO-covered diagnosis. These visits should be billed to the appropriate BHO and costs related to these visits must be adjusted out of the cost report in Column 8.

**Line 16-Mental Health Workers-Non-BHO** – Costs incurred for mental health workers (licensed professional counselors and registered psychotherapists) who are furnishing direct health care services to patients that are not for a BHO-covered diagnosis.

**Line 17-Mental Health Workers-BHO** – Costs incurred for mental health workers (licensed professional counselors and registered psychotherapists) who are furnishing direct health care services to patients that are for a BHO-covered diagnosis. These visits should be billed to the appropriate BHO and costs related to these visits must be adjusted out of the cost report in Column 8.

**Line 18-Laboratory-Medical** – Costs incurred for in-house laboratory services including staff salary, fringe benefits and supplies. Do not include off-site laboratory costs on this line as they are to be reported in the Non-Reimbursable Section, Line 46. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third party payers, the costs associated with that service may remain in the cost report.

**Line 19-X-Ray-Medical** – Costs incurred for in-house radiology services including staff salary, fringe benefits and supplies. Do not include off-site radiology costs on this line as they are to be reported in the Non-Reimbursable Section, Line 46. If the FQHC can demonstrate through contract with the off-site radiology contractor that only the FQHC is billed for services rendered, and not third party payers, the costs associated with that service may remain in the cost report.

**Line 20-Pharmacy** – The determination of whether pharmacy costs are included as Covered Health Care Costs depends upon how pharmacy services are delivered at the FQHC. If a FQHC operates its own pharmacy that serves Medicaid patients, it must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number. In this case, because pharmacy costs are paid to the FQHC via a dispensing fee, all costs related to the pharmacy, including drug costs and administrative costs, are excluded from the cost report and must be adjusted out on Worksheet 1 – Supplement 2 – Adjustments to Expenses.

For those FQHCs that acquire a separate pharmacy Medicaid billing number during the fiscal year, there may be a partial period that the FQHC was not reimbursed for pharmacy services via the dispensing fee. In this case, as long as the FQHC served Medicaid patients during that partial period, pharmacy costs remain in the cost report, and reimbursement to the FQHC becomes part of the encounter rate calculation.

If a FQHC operates its own pharmacy and does not serve Medicaid patients, the costs are removed from the cost report on Worksheet 1 – Supplement 2 – Adjustments to Expenses (10 CCR 2505-10 8.700.5.B.3).

According to the Colorado Medicaid Provider Bulletin dated October 2014, providers that participate in the federal 340B Drug Pricing Program must document and ensure their compliance with all 340B Drug Pricing Program requirements. If providers choose to purchase and dispense 340B drugs to their Medicaid members, they must inform the Health Resources and Services Administration (HRSA) at the time of enrollment in the 340B Program by providing their Medicaid provider and National Provider Identifier (NPI) numbers. This information will be reflected on the HRSA Medicaid Exclusion File so that states and manufacturers can verify that drugs purchased under a Medicaid provider number are also eligible for a Medicaid rebate. If providers decide to bill Medicaid for drugs purchased under 340B, then all drugs billed under that Medicaid provider number/NPI must be purchased under 340B. For providers that opt to purchase Medicaid drugs outside of the 340B Program, all drugs billed under that Medicaid provider number/NPI must be purchased outside the 340B Program; the Medicaid provider number/NPI should not be listed on the HRSA Medicaid Exclusion File.

Some FQHCs establish 340B program contracts with outside companies to make prescription drugs available to FQHC patients at retail pharmacies. These contracts must be written to exclude Medicaid patients from the 340B program because the State of Colorado is eligible for rebates on pharmaceuticals provided to Medicaid patients. It is illegal for the State to get a rebate for a pharmaceutical provided to a Medicaid patient and for the prescription to be filled with discounted 340B drugs. HRSA, as well as the Centers for Medicaid and Medicare Services (CMS), place the burden of properly managing these 340B programs on the FQHC.

Because 340B program contracts are not applicable to Medicaid patients, the costs of these programs, up to the amount of revenue generated, must be removed from the cost report on Worksheet 1 – Supplement 2 – Adjustments to Expenses. Costs of this type of 340B program include the cost of the drugs purchased, fees incurred and paid to the contracted company to administer the program, and any other costs specifically incurred for the contracted program.

Example: A FQHC has a contract with Capture Rx and the following figures are available:

- Revenue generated = \$200,000
  - Cost of drugs = \$70,000
  - Fees paid to Capture Rx = \$80,000
  - Revenue in excess of expense = \$50,000

The FQHC must remove the costs (\$70,000 and \$80,000) from the cost report.

Pharmaceuticals used during a visit are incident to the provided service and remain in the cost report (aspirin, vaccines, etc.)

**Line 21-Speech Pathology** – Speech pathologists are not approved providers under the FQHC encounter rate methodology and do not generate a FQHC encounter. Visits by speech pathologists who are furnishing direct health care services to patients can be billed on a fee-for-service basis or as incident to an approved provider visit, but not both. If billed fee-for-service, costs should be adjusted out of the cost report and the final figure in Column 9 should be zero.

**Line 22-Occupational Therapy** – Occupational therapists are not approved providers under the FQHC encounter rate methodology and do not generate a FQHC encounter. Visits by occupational therapists who are furnishing direct health care services to patients can be billed on a fee-for-service basis or as incident to an approved provider visit, but not both. If billed fee-for-service, costs should be adjusted out of the cost report and the final figure in Column 9 should be zero.

**Line 23-Physical Therapy** – Physical therapists are not approved providers under the FQHC encounter rate methodology and do not generate a FQHC encounter. Visits by physical therapists who are furnishing direct health care services to patients can be billed on a fee-for-service basis or as incident to an approved provider visit, but not both. If billed fee-for-service, costs should be adjusted out of the cost report and the final figure in Column 9 should be zero. Visits for physical therapy services delivered by an approved provider (i.e. physician, midlevel) may be billed via the encounter rate with the costs reported on this line.

**Line 24-Vocational Therapy** – Vocational therapists are not approved providers under the FQHC encounter rate methodology and do not generate a FQHC encounter. Visits by vocational therapists who are furnishing direct health care services to patients can be billed on a fee-for-service basis or as incident to an approved provider visit, but not both. If billed fee-for-service, costs should be adjusted out of the cost report and the final figure in Column 9 should be zero.

**Line 25-Health Education** – Costs incurred for delivery of health education information or materials directly to patients. Included are healthy diet programs and nutritional counseling if performed by a registered dietician, smoking cessation programs, etc.

**Line 26-Medical Records** – Costs incurred for time spent by clinic staff directly on patient medical records. Oftentimes, clinic staff will perform a variety of duties including medical records. Staff that perform medical records tasks, as well as other clerical tasks, must have their costs split between covered health care costs and overhead. All clinic staff costs other than those specific to medical records go in Part C: Overhead Costs of Worksheet 1.

**Line 27-Patient Transportation** – Costs incurred for transporting patients, as well as staff travel costs that are directly incurred for patient care and are reasonable in amount.

**Line 28-Durable Medical Equipment** – Costs incurred for renting equipment such as crutches, wheelchairs, oxygen tanks, etc. related to patient care.

**Line 29-Malpractice-Physician** – Costs incurred for the portion of malpractice insurance relative to the providers and not to administrative staff. The providers of most FQHCs are covered for malpractice through the Federal Tort Claims Act (FTCA) and there is no cost to the FQHC; however, some FQHCs carry gap policies.

**Line 30-Medical Supplies** – Costs incurred for the purchase and utilization of medical supplies in the FQHC clinics.

**Line 31-Medical and Dental Equipment Repairs & Maintenance** – Costs for minor repairs and maintenance to equipment utilized to deliver clinical services to patients.

**Line 32-Medical and Dental Small Equipment** – Costs for the purchase of equipment utilized to deliver clinical services to patients under the Federal capitalization threshold of \$5,000.

**Line 33-On-Call Services** – Costs incurred to pay physicians for providing on-call services on an inpatient basis. These services are billed on a fee-for-service basis and the costs should be adjusted out of the cost report in Column 8.

**Lines 34-39 – Other (Specify)** – Lines 34 through 39 are to be used to report any other covered health care costs that do not fit on lines 1 through 33. Examples include case management, referral coordinators, outreach and enrollment staff, outreach activities targeted at the FQHC’s target population with the intent of making individuals aware of the services available and how to access them, risk assessment, translation, transcription, transportation costs incurred by health care staff etc. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and the FQHC should be prepared to document all expenses if requested by the auditor.

**Line 40-Total Covered Health Care Costs** – Total of all costs on Lines 1 through 39.

#### **Section B: Non-Reimbursable Costs**

Costs incurred to provide services that are not reimbursed under Colorado’s Medicaid State Plan Amendment, are not in the FQHC’s scope of project, or do not meet the Medicare definition of FQHC services. Examples include the Women, Infants & Children Program (WIC) and the Nurse Home Visitor Program. If it is not clear whether program costs should be included in the Non-Reimbursable Section, the auditor/contractor should be contacted for a determination.

**Line 41-Education** – Costs incurred for group or mass information programs or activities, including media productions and publications. Direct health education provided directly to a patient one-on-one is reported on Line 25 in Section A.

**Line 42-Outreach** – Costs incurred to perform outreach services into the general community. Costs incurred to perform targeted outreach with the intent of notifying the FQHC’s target population of accessibility and services available should be reported under “other” in Section A. For further clarification on allowable and unallowable outreach costs as they relate to advertising and marketing, see the [Medicare Provider Reimbursement Manual, Part 1](#), Chapter 21, Section 2136.

**Line 43-Community Service** – Costs incurred by the FQHC to participate in community service events and activities.

**Line 44-Environmental** – Costs incurred by the FQHC to improve the environmental conditions in the service area.

**Line 45-Research** – Costs incurred by the FQHC for any type of research and/or testing.



**Line 46-Offsite Laboratory/X-Ray/Specialty Care Office Visits** – Costs paid by the FQHC for laboratory, radiology, specialty care, etc. are non-reimbursable as these visits are typically billed to Medicaid by the provider of the service. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third party payers, the costs associated with that service should be included on Line 18.

**Line 47-Nurse Home Visitor/Partnership** – Costs incurred through a separate contract with the State of Colorado to deliver in-home education to first time, low-income mothers. This program is reimbursed to the FQHC separately from the encounter rate and must be reported as non-reimbursable in the cost report.

**Lines 48-51 – Other (Specify)** – Lines 48 through 51 are to be used to report any other non-reimbursable costs that do not fit on Lines 41 through 47. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule.

**Line 52-Total Non-Reimbursable Costs** – Total of all costs on Lines 41 through 51.

### **Section C: Overhead Costs**

Costs incurred to transform materials into a finished health care product that are not directly allocable to covered health care costs. Overhead labor includes the cost of employees who do not work directly on the product or service, but are necessary for the health care facility to operate, such as supervisors, inventory storekeepers, janitors, and maintenance workers. Overhead materials include the cost of repair parts for non-medical equipment, light bulbs, and other costs which are not a part of the finished health care product, but are necessary to produce the health care product or service. Other overhead costs include items such as depreciation on the health care facility buildings and equipment, taxes on the assets, insurance on the buildings and equipment, security, heat, light, power, and similar costs incurred to keep the health care facility operating.

**Line 53-Administration** – Costs incurred for administrative staff such as the chief executive officer, the executive director, administrative assistants, secretaries, business managers, clinic managers, front desk supervisors, office technicians, special projects staff, medical office managers, and any other staff that do not participate in the direct delivery of health care products and services but are necessary for operation of the FQHC.

Administrative time of provider staff (chief medical officer, medical director, and assistant medical director) should be included on Line 53 and will most likely be reclassified from Lines 1-4 in Section A.

Other costs reportable on Line 53 include the following:

- Board of Directors – stipends, mileage, meetings, retreats
- Maintenance fees for administrative buildings and equipment
- Contract services for administrative projects – interim administrative staff, etc.
- Dues & subscriptions for the company – not specific to a provider contract
- Recruitment costs – administrative staff; costs incurred for recruitment of staff reported in Section A – Covered Health Care Costs – can be reported in that section.
- Printing – brochures, patient handbooks, forms, etc.

- License fees for the company or administrative staff

Advertising costs are allowable if they are appropriate and helpful in developing, maintaining, and furnishing covered services to patients. Advertising costs that are incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Costs of advertising for the purpose of recruiting staff are allowable if the personnel would be involved in patient care activities or in the development or maintenance of the facility. Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services, are allowable. Costs of informational listings in a telephone directory are allowable.

Interest costs, with the exception of mortgage interest, are reported on Line 53. This would include interest incurred on lines of credit, financing of equipment, etc.

**Line 54-Financial** – Costs incurred for financial staff such as the chief financial officer, finance director, controller, assistant controller, accountants, accounting technicians, accounts payable clerks, payroll clerks, etc.

Other costs reportable on Line 54 include the following:

- audit fees
- financial statement preparation costs
- costs of financial consultants

**Line 55-Marketing** – Costs of advertising to the general public are not allowable as these costs are not properly related to the direct care of patients. Advertising costs related to fundraising are also not allowable. Staff that performs marketing functions should be included here as well. For further clarification on allowable and unallowable advertising and marketing costs, see the [Medicare Provider Reimbursement Manual, Part 1](#), Chapter 21, Section 2136. These costs should be reported on Line 55 and will be adjusted out in Column 8.

**Line 56-Legal** – Includes all legal costs including attorney fees, court costs, out-of-court settlements, etc.

**Line 57-Information Technology (IT)** – Costs incurred for information technology staff including the director, assistant director, coordinator, programmers, technicians, computer operators, etc. Additionally, costs for billing and coding staff should be reported here. Also include other IT costs such as software and hardware upgrades and maintenance agreements.

**Line 58-Housekeeping** – Costs incurred for janitorial staff or contracted labor. Also include janitorial supplies.

**Line 59-Maintenance/Repair** – Costs incurred for maintenance/repair of administrative facilities and equipment. Also include the cost of waste disposal.

**Line 60-Security** – Costs incurred for security staff, non-depreciable security systems (cost of \$5,000 or less) and security monitoring fees.

**Line 61-Supplies** – Costs incurred for administrative supplies used in clinics, office supplies, postage, books, accounting supplies, medical records supplies, etc. Additionally, non-clinical and office equipment purchased at a cost under the Federal capitalization threshold of \$5,000 is reported as supplies in the overhead section.

**Line 62-Insurance** – Costs incurred for insurance including the following:

- building coverage
- equipment coverage
- vehicle coverage
- liability coverage
- errors & omissions coverage
- employee theft or embezzlement

Do not include the cost of provider malpractice insurance as this should be reported on line 29.

**Line 63-Telephone** – Costs incurred for telephone expense (land lines, cell phones, pagers, answering service) as well as for phone system leases.

**Line 64-Utilities** – Costs incurred for utilities for the FQHC facilities including heat, electricity, etc.

**Line 65-Rent** – Costs incurred for rental of facilities, equipment, vehicles, and any other type of rental or lease costs. If the FQHC records expense for donated rent, this must be adjusted out in Column 8.

**Line 66-Depreciation** – Expense recorded for depreciation of the capitalized cost of the following items: medical equipment, non-medical equipment, furniture, office equipment, computer equipment, buildings, vehicles, etc. The FQHC must be the recorded title holder of the equipment and the assets must be identifiable and recorded in the FQHC's accounting records in accordance with Generally Accepted Accounting Principles. Single items of equipment valued at a cost of \$5,000 or more with an estimated life of over one year are to be depreciated. Depreciation must be prorated over the estimated useful life of the asset using the straight line method. The estimated useful life of a depreciable asset is its normal operating or service life to the FQHC. Leasehold improvements may be depreciated over the shorter of the asset's useful life or the remaining life of the lease. The fixed asset records shall include for each asset: a description, the date acquired, estimated useful life, depreciation method, historical cost or fair market value, salvage value, depreciable cost, depreciation for the current reporting period, and accumulated depreciation.

**Line 67-Amortization** – Expense recorded for amortization of the capitalized cost of items such as bond costs, loan costs, etc.

**Line 68-Contributions** – Costs incurred for contributions to other entities including those related to the provision of health care and those that are not directly related to health care.

**Line 69-Transportation** – Costs incurred for by non-health care staff for travel and transportation including the following: non-patient transportation, messenger service, mileage, medical records transportation, etc. Health care staff travel and transportation costs can be reported in Section A – Covered Health Care Costs.

**Line 70-Mortgage Interest** – Costs incurred for real estate mortgage interest. This line is only for interest paid on facility debt. All other interest (lines of credit, equipment loans, etc.) is to be reported on Line 53. Interest income, up to the amount of interest expense, will be adjusted out in Column 8.

**Line 71-Malpractice-Clinic** – Costs incurred for the purchase of malpractice insurance for non-providers and other costs such as deductibles and co-payments. The cost of malpractice insurance purchased for provider staff is reported on Line 29.

**Line 72-Property Tax** – Costs incurred for property tax on property used in the FQHC operation.

**Lines 73-79 – Other (Specify)** – Lines 73 through 79 are to be used to report any other overhead costs that do not fit on Lines 53 through 72. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule.

**Line 80-Total Overhead Costs** – Total of all costs on Lines 53 through 79.

**Section D: Total Costs**

Total of Sections A, B and C (Lines 40, 52 and 80).

## **WORKSHEET 1 – SUPPLEMENT 1 – RECLASSIFICATIONS**

Worksheet 1 – Supplement 1 is used to report and explain cost reclassifications that are reflected in Column 6 of Worksheet 1. This form provides for the reclassification of certain costs to reflect the proper cost reporting as covered health care costs, non-reimbursable costs or overhead costs. Reclassifications are necessary in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet 1 are maintained in the facility's accounting books and records in one cost center or account.

Examples of costs that require reclassification are as follows:

- It is common for a provider to perform administrative duties as a chief medical officer, medical director, or assistant medical director, and also spend time delivering health care services directly to patients. Often 100% of the salary and fringe costs for these providers are reported in the Covered Health Care Costs section of Worksheet 1. The appropriate portion of the provider salary and fringe benefits relative to the administrative duties should be reclassified from the Covered Health Care Costs section to the Overhead Costs section. If the FQHC records the administrative portion of the salary and fringe in a separate account in the accounting system, no reclassification is necessary.
- Oftentimes, FQHC providers, particularly in rural areas, will deliver health care services to a patient on an inpatient basis in the hospital. These services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate. Again, it is common for 100% of the salary and fringe costs for these providers to be reported in the Covered Health Care Costs section of Worksheet 1. Therefore, the portion of salary and fringe benefits relative to inpatient health care services should be reclassified from the Covered Health Care Costs section to the Non-Reimbursable Costs section. If the FQHC has no providers who deliver health care services in the hospital setting, no reclassification is necessary.

### **Column Descriptions and Instructions**

#### **Explanation of Entry**

Enter in this column an explanation of the reclassification such as 'physician administrative time' or 'physician inpatient time'.

#### **Column 1-Code**

Enter an alphabetical code in this column to identify each reclassification entry. The first will be A, and then B, and so on.

#### **Column 2-Cost Center**

Enter in this column the name of the Cost Center (line) from Worksheet 1 that will be increased by the reclassification.

#### **Column 3-Line Number**

Enter in this column the line number relative to the Cost Center in Column 2 that will be increased by the reclassification.

**Column 4-Amount**

Enter in this column the amount by which the Cost Center in Column 2 will be increased.

**Column 5-Cost Center**

Enter in this column the name of the Cost Center (line) from Worksheet 1 that will be decreased by the reclassification.

**Column 6-Line Number**

Enter in this column the line number relative to the Cost Center in Column 2 that will be decreased by the reclassification.

**Column 7-Amount**

Enter in this column the amount by which the Cost Center in Column 2 will be decreased.

After all reclassification entries have been entered, the total of Columns 4 and 7 are entered on Line 36. The total of each column should agree to the other. The reclassification entries are then transferred to the appropriate lines on Worksheet 1, Column 6.

## **WORKSHEET 1 – SUPPLEMENT 2 – ADJUSTMENTS TO EXPENSES**

This form provides for necessary adjustments to the expenses listed on Worksheet 1. Many of these adjustments follow the Medicare rules and regulations. All of the unallowable costs reported on Addendum 2 will be transferred to Worksheet 1 – Supplement 2. Additionally, other cost adjustments that are not defined as unallowable, but are adjustments nonetheless will be recorded on Worksheet 1 – Supplement 2. Finally, the total of both types of adjustments is transferred to Column 8 of Worksheet 1.

Pre-printed line descriptions indicate the more common activities that result in adjustments to expenses. There are also a number of blank lines to record adjustments not specifically identified on the form and specific to individual FQHCs.

### **Column Descriptions:**

#### **Explanation of Entry**

Enter an explanatory description of the type of cost adjustment.

#### **Column 1-Cost Center**

Enter the title of the cost center on Worksheet 1 that is being adjusted.

#### **Column 2-Amount**

Enter the dollar amount of the cost adjustment (reduction in expense).

#### **Column 3-Line Number**

Enter the line number on Worksheet 1 that is being adjusted.

### **Line Descriptions:**

**Line 1-Offsite Lab/X-Ray/Specialty** – Patient visits for laboratory, radiology, and specialty care are typically billed to Medicaid by the provider of the service. Therefore, costs incurred by the FQHC for these services are non-reimbursable to the FQHC via the encounter rate and must be adjusted off of Worksheet 1. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third party payers, the costs associated with that service should be included on Line 18 of Worksheet 1.

**Line 2-Pharmacy** – As noted in the instructions for Line 20 of Worksheet 1 (Pharmacy), some or all of the pharmacy costs incurred by the FQHC may require adjustment. If the FQHC recovers pharmacy costs for Medicaid patients via a dispensing fee, all costs relative to the pharmacy are excluded from the cost report and must be adjusted off. Also, if the FQHC does not serve Medicaid patients, the costs are adjusted off. Finally, if the FQHC operates a contracted 340B program through an outside company (Capture Rx, Walgreens), which is not applicable to Medicaid patients, the costs of this program, up to the amount of revenue generated, must be removed from the cost report. Costs of this type of 340B program include the cost of the drugs purchased, fees incurred and paid to the contracted company to administer the program, and any other costs specifically incurred for the contracted program.

**Line 3-BHO** – Costs incurred for any provider (psychologist, psychiatrist, licensed professional counselors, registered psychotherapists, etc.) to furnish direct health care services to patients resulting in a BHO-covered diagnosis must be adjusted out because these visits should be billed to the appropriate BHO. The costs cannot be part of the FQHC encounter rate.

**Line 4-ACC PMPM-State of Colorado** – FQHCs that participate with one of Colorado Medicaid’s Accountable Care Collaboratives (ACC) are paid a per member per month (PMPM) fee for each patient enrolled in the ACC. The PMPM shall not be considered when calculating the per-visit encounter rate provided for in 10 CCR 2505-10 8700.6. If the FQHC utilizes the funds on Medicaid-covered services, costs up to but not exceeding the received PMPM funds must be excluded from the cost report. If the FQHC can demonstrate it is not spending the PMPM on an allowable expenses, then it does not off-set PMPM costs in the cost report. If the FQHC cannot demonstrate this, then funds (ACC-attributed enrollees x monthly PMPM) are used as a proxy for expense. Please note, this treatment is not applicable to PMPM payments paid by the ACC RCCOs to FQHCs.

**Line 5-Outstationing** – As described in the manual section on outstationing, the FQHC will be paid the lower of actual outstationing costs or the amount calculated by multiplying the total number of applications by the reimbursement rate. Whichever amount the FQHC is paid for outstationing activities must be adjusted out of the cost report as the FQHC cannot receive a lump sum payment and also have the costs included in the encounter rate calculation. If the actual costs are more than the amount the FQHC is reimbursed for outstationing, the excess costs may remain in the cost report for the encounter rate calculation.

**Line 6-Lobbying** – Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

**Line 7-Marketing** – Costs incurred for unallowable marketing are not allowable as these costs are not properly related to the direct care of patients. These costs include salary and fringe of staff that perform marketing functions as well as advertising to the general public. For further clarification on allowable and unallowable advertising and marketing costs, see the [Medicare Provider Reimbursement Manual, Part 1](#), Chapter 21, Section 2136. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

**Line 8-Miscellaneous Income** – Some types of miscellaneous income earned by the FQHC must be reported and offset against expense. Miscellaneous income is defined as income generated that is not directly related to patient care and includes items such as expense rebates, medical records copy fees, etc. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

**Line 9-Interest Income** – Interest income earned by the FQHC must be reported and offset against interest expense, but only up to the amount of interest expense. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

**Line 10-Lease Income** – Lease income earned by the FQHC must be adjusted out of the cost report and should be offset against facility costs.



**Line 11-Physician Hospital** – As described in the manual section on reclassifications, FQHC providers, particularly in rural areas, will deliver health care services to a patient on an inpatient basis in the hospital. These services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate and the cost for these services must be adjusted off.

**Line 12-Bad Debt** – Bad debt expense incurred by a FQHC, if applicable, is not an allowable cost and must be adjusted off.

**Line 13-Fundraising** – Costs of fundraising for the FQHC are not allowable and must be adjusted off. These costs include salary and fringe of staff that perform fundraising tasks, advertising costs, and any other costs specifically related to fundraising.

**Line 14-In-Kind/Donated Costs** – Some costs are recorded in the financial statements (under Generally Accepted Accounting Principles) to reflect donations to the FQHC organization. These costs (rent, supplies, equipment, etc.) must be adjusted off. Costs associated with maintaining donated equipment are allowable and should be included in Lines 59 and 66 on Worksheet 1.

**Lines 15-37 – Other (Specify)** – There are a number of blank lines on Worksheet 1 – Supplement 2 – Adjustments to Expenses for reporting of other adjustments specific to each FQHC.

**Line 38-Total** – This is the total amount of all adjustments entered in column 2 – Amount. Once all adjustments have been entered on Worksheet 1 – Supplement 2, each adjustment amount must be entered in Column 8 (Adjustments) of Worksheet 1. The total on Worksheet 1, Line D, Column 8 should agree to the total on Worksheet 1 – Supplement 2.

## WORKSHEET 2 – FQHC PROVIDER STAFF, VISITS AND PRODUCTIVITY

Worksheet 2 is used to report the full time equivalent (FTE) of physicians, mid-levels, and other provider staff, and the number of visits delivered by each provider category during the reporting period. Worksheet 2 also applies a productivity standard to medical providers to determine whether actual visits or expected productivity standard visits will be used in the rate calculation.

### **Part A-FQHC Provider Staff and Visits**

#### **Columns 1-3 – FTE**

Calculate FTEs based on the FQHC's normal hours for full-time employment. Note that 2,080 is the maximum number of paid hours to be considered full-time. The FTE for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time, per the [Medicare Benefit Policy Manual, Chapter 13](#), Part 70.4. For providers who deliver health care services on an inpatient basis (hospital rounds), only the FTE relative to the delivery of outpatient services should be reported. The FTE relative to the inpatient services is not reported as these services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate. Enter the total FTEs on the appropriate lines of Worksheet 2, Columns 1-3. Column 1 is to be used for contracted providers and Column 2 is to be used for providers who are on staff and paid as employees. Column 3 reflects the total FTE for each provider category.

Personnel records, contracts and agreements in support of reported FTE must be maintained and available for review by the cost report auditor/contractor.

Non-provider FQHC staff should also have the FTEs calculated for each position using the same methodology, and reported on a separate auxiliary schedule. See example in Appendix C.

#### **Columns 4-6 – Visits/Encounters**

“Visit” means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker. Group sessions do not generate a billable encounter for any FQHC services (10 CCR 2505-10 8.700.1).

All encounters must be reported, even those for which the FQHC is unable to collect a payment or chooses not to bill for the service.

Enter the total visits on the appropriate lines of Worksheet 2, Columns 4 through 6. Column 4 is to be used for visits delivered at a clinic site operated by the FQHC directly. Column 5 is to be used for visits delivered to FQHC patients at a site not operated by the FQHC directly, such as a nursing home. Visits delivered in a hospital setting are **not** reported in the cost report as these services are paid to the FQHC on a fee-for-service basis rather than part of the encounter rate. Column 6 reflects the total number of visits for each provider category.

The subtotals of FTE in Columns 1 through 3 and visits in Columns 4 through 6 for medical providers only (physicians, physician assistants, nurse practitioners, and certified nurse midwives) should be

recorded on Lines 1 through 3. These subtotals will be used in the productivity standard calculations in Part B of Worksheet 2.

Only data (FTE and visits) for those providers approved by the State of Colorado per 10 CCR 2505-10 8.700.1 (physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, and clinical social worker) are to be reported on Worksheet 2.

The totals of FTE in Columns 1 through 3 and visits in Columns 4 through 6 should be recorded on Line 13.

#### **Part B-Minimum Medical Team Productivity**

For rate determination, the State applies a productivity standard of 4,200 encounters for each FTE physician and 2,100 encounters for each FTE non-physician practitioner as the minimum standard of productivity. Part B of Worksheet 2 applies this productivity standard to the FTE reported by the FQHC in Part A and determines whether actual visits or productivity standard visits will be used in the rate calculation.

**Line 14** – Enter the total number of visits delivered by medical providers from Part A, Column 6, Line 3.

**Line 15** – Enter the total medical provider FTE for the minimum medical team productivity standard calculation which is 100% of the physician FTE reported in Part A, Column 3, Line 1 plus 50% of the mid-level FTE reported in Part A, column 3, Lines 2 through 2.2.

**Line 16** – Calculate the minimum medical team productivity by multiplying Part B, Line 15 by 4,200 and enter the result. This is the expected number of visits under the minimum medical team productivity methodology.

**Line 17** – Enter the medical provider visits to be used in rate determination, which is the greater of Part B, Line 14 or Line 16.

**Exception to Productivity Standards** - Productivity standards established by the State of Colorado are guidelines that reflect the total combined services of the staff. If the FQHC does not meet the productivity standards, an exception may be granted based upon specific circumstances. Examples of reasons for not meeting the productivity standards include the following: newly designated FQHC entities, newly established FQHC sites, new FQHC provider staff with low volume, a FQHC that provides the majority of services to special populations, implementation of an electronic medical record, etc.

The cost report auditor/contractor has the authority to make an exception to productivity guidelines in cases where the FQHC has demonstrated reasonable justification for not meeting the standard. In such cases, the FQHC should contact the cost report auditor/contractor directly to determine the possibility of a productivity standard exception. At this point, the cost report auditor/contractor will request additional data as necessary to make the determination. This should be done prior to submission of the cost report. Exceptions to the productivity standards are at the discretion of the cost report auditor/contractor and the

State of Colorado and may be granted on an annual basis; provider productivity must be re-evaluated each year.

**Part C-Provider Visits for Rate Determination**

This section calculates the number of provider visits that will be used in the FQHC rate determination.

**Line 18** – Enter the total of all other provider visits excluding the medical provider visits, which is Part A, Column 6, Line 13 minus Part A, Column 6, Line 3.

**Line 19** – Enter the total number of provider visits to be used for rate determination, which is Part B, Line 17 plus Part C, Line 18. This visit number is then transferred over to Worksheet 3, Part B, Line 10.

## **WORKSHEET 3 – DETERMINATION OF FQHC OVERHEAD AND ENCOUNTER RATE**

Worksheet 3 is designed to bring together information on all the other forms in order to allocate overhead, calculate total FQHC allowable costs, and determine the FQHC rate.

### **Part A-Determination of Overhead Applicable to FQHC Services**

**Line 1** – Enter the total cost of FQHC services excluding overhead (covered health care costs) from Worksheet 1, Column 9, Line 40.

**Line 2** – Enter the total non-reimbursable FQHC costs excluding overhead from Worksheet 1, Column 9, Line 52.

**Line 3** – This is the sum of Lines 1 and 2 and represents the cost of all services excluding overhead.

**Line 4** – This is the percentage of non-reimbursable FQHC costs and is calculated by dividing the figure on Line 2 by the figure on Line 3.

**Line 5** – Enter the total overhead cost from Worksheet 1, Column 9, Line 80.

**Line 6** – This is the amount of the overhead cost that is applicable to non-reimbursable cost and is calculated by multiplying Line 5 by Line 4.

**Line 7** – This is the amount of overhead cost that is applicable to FQHC services and is calculated by subtracting the figure on Line 6 from the figure on Line 5.

**Line 8** – This is the total cost of FQHC services after allocation of overhead cost. It is the sum of Line 1 and Line 7.

### **Part B-Determination of FQHC Rate**

**Line 9** – This is the total cost of FQHC services and is the same as the amount on Line 8 in Part A.

**Line 10** – This is the FQHC provider visits to be used in the rate determination. It is the number of visits transferred from Worksheet 2, Part C, Line 19.

**Line 11** – This is the calculated FQHC encounter rate before adjustments for inflation and is calculated by dividing the figure on Line 9 by the figure on Line 10.

### **To Be Completed by Department**

This section is not to be completed by the FQHC as the State of Colorado will apply the current inflation factor and calculate the final effective encounter rate.

## **ADDENDUM 1 – ENCOUNTER REPORT**

Addendum 1 is designed for the FQHC to report the total visits reported on Worksheet 2 in several different groupings.

In the first section of this form, the FQHC reports total encounters and Medicaid encounters broken down into those that are HMO encounters and those that are not. The total encounter number in the second column is carried down to the reconciliation on the bottom of the page. Total encounters reported on Addendum 1 should be the same as total encounters on Worksheet 2, Column 6, Line 13. If there is a variance, it should be explained.

The second section of this form is for reporting mental health, or behavioral health, encounters only. Again, the first column is for Medicaid encounters and the second column is for total encounters. These encounters are a subset of the total encounters reported in the first section. The behavioral health encounters are also to be broken down into those that are BHO encounters and those that are not.

## ADDENDUM 2 – UNALLOWABLE EXPENSES

As noted in the Worksheet 1 instructions, some expenses of the FQHC are unallowable for the Medicaid Cost Report. Unallowable costs include, but are not limited to, expenses that are incurred by a FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. A FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per-visit encounter rate for Medicaid clients (10 CCR 2505-10 8.700.5.B).

Addendum 2 is provided so that the FQHC can determine if unallowable costs have been incurred and, if so, the dollar amount to be adjusted out of the expenses on Worksheet 1. All expenses noted in this Addendum must be transferred to Worksheet 1, Supplement 2.

For each listed expense category, the FQHC should select yes or no as to whether the expense has been incurred during the reporting period. If the FQHC has incurred expense, the dollar amount and general ledger account number should be noted.

### **Line Descriptions:**

**Line 1-Alcoholic Beverages** – The cost of alcoholic beverages of any kind, for any reason, are unallowable. This includes social events that may be hosted by the FQHC as well as alcoholic beverages purchased by employees who are traveling out of town on business.

**Line 2-Lobbying Expense** – Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable.

**Line 3-Personal Use of Autos** – The cost of a company vehicle used for FQHC purposes is allowable; however, the cost of any personal use of a company vehicle is not. For example, if an employee maintains use of a company vehicle for business and personal use, and is taxed on the personal use at the end of each tax year, the cost related to the personal use must be removed from the cost report as unallowable.

**Line 4-Gifts and Donations** – The cost related to the FQHC giving gifts and donations to other entities or people is unallowable. Examples include donations to Local Fun Runs, donations in lieu of flowers, etc. This should align with Line 66 on Worksheet 1.

**Line 5-Promotional Items** – The cost of any items purchased and distributed for promotional purposes in order to increase the number of patients who use the FQHC is unallowable.

**Line 6-Sports and Other Tickets** – The cost incurred by the FQHC for any type of sporting or other tickets is unallowable.

**Line 7-Other Entertainment** – The cost incurred by the FQHC for any other type of entertainment besides sports and other tickets is unallowable.

**Line 8-Advertising** – Costs of advertising to the general public are not allowable as these costs are not properly related to the direct care of patients. Advertising costs related to fundraising are also not allowable. For clarification on allowable and unallowable advertising costs, see the [Medicare Provider Reimbursement Manual, Part 1](#), Chapter 21, Section 2136.

**Line 9-Marketing Salary and Related Costs** – The costs of staff that perform marketing functions as described in Line 8 are unallowable. This includes the salary cost and the related fringe.

**Line 10-Costs Incurred on Behalf of Related Organizations** – Any costs incurred related to an organization related to the FQHC are not allowable.

**Line 11-Fines and Penalties** – If the FQHC has been subject to the payment of any fines or penalties of any kind, these costs are unallowable.

**Line 12-Country Club Dues** – The cost of country club dues paid on behalf of the FQHC or any of its employees is unallowable.

**Line 13-Educational Expenses for Spouse or Other Relatives** – If the FQHC incurs costs to pay for educational expenses of spouses or other relatives of the FQHC's employees, these costs are unallowable.

**Line 14-Cost of Travel Incurred in Connection with Non-patient Care Related Purposes** – Most travel costs of a FQHC are incurred in the provision of health care services to patients; however, if travel costs are incurred that are clearly not related to patient care, these costs are unallowable.

**Line 15-Costs Associated with Reorganizations, Mergers, Acquisitions, etc.** – Costs incurred by the FQHC related to reorganizations, mergers, or acquisitions are unallowable.

**Line 16-Miscellaneous Income** – Some types of miscellaneous income earned by the FQHC must be reported and offset against expense. Miscellaneous income is defined as income generated that is not directly related to patient care and includes items such as expense rebates, medical records copy fees, etc.

**Line 17-Interest Income** – Interest income earned by the FQHC must be reported and offset against interest expense, but only up to the amount of interest expense.

**Line 18-Other (Specify)** – Any other unallowable costs incurred by the FQHC are reported under "Other" with an explanation of the cost.

**Line 19-Total** – The total unallowable expense reported in Line 1 through Line 18.

Each of the unallowable expenses reported on Addendum 2 must be transferred to Worksheet 1 –

Supplement 2 – Adjustments to Expenses.



## **OUTSTATIONING OF ELIGIBILITY WORKERS**

### **ACTIVITIES AND REPORTING**

Each FQHC that participates in the State Medicaid program must have a person qualified to take Medicaid applications and assist applicants with the application process. When a FQHC has more than one site, applications for Medicaid must be taken at all sites during the normally scheduled site hours of operation. Initial processing means taking applications, assisting applicants in completing the application, providing information and referral, obtaining required documentation needed to complete processing of the application, assuring completeness of the information contained on the application, and conducting interviews. Initial processing does not mean evaluating the information contained on the application and the supporting documentation or making a determination of eligibility or ineligibility (CMS State Organization and General Administration Manual, sections 2905-2913).

FQHCs will be reimbursed a portion of reasonable cost for enrollment outstationing activities provided to patients. It should be noted that outstationing reimbursement is only applicable to Medicaid application assistance and does not apply to other types of medical assistance applications.

Examples of application assistance that are NOT reimbursed include the following:

- Women, Infants & Children (WIC)
- AmeriCorps
- Nurse Home Visitor Program
- Pre-Natal Plus Program
- Child Health Plan (CHP)
- Child Health Plan + (CHP+)
- Colorado Indigent Care Program (CICP)
- Breast & Cervical Cancer Program (BCCP)
- FQHC Sliding Fee Scale

The FQHC reports actual costs of outstationing activities and will be paid the lower of actual costs or a reasonable cost per application rate established by the State. The current rate is \$12.66 per application. The maximum annual payment is \$60,000 and this payment is made outside of the cost report. The lump sum payment to the FQHC for outstationing must be adjusted out of the cost report as the costs cannot be reimbursed as part of the encounter rate and through a lump sum payment.

**Please note that it is the responsibility of the FQHC to correctly complete the outstationing forms. (See Appendix A for a complete set of the Outstationing Forms). If the forms are not completed, there will be no reimbursement paid to the FQHC for outstationing activities.**

## **Workpaper A-Medicaid Outstationing Activity**

Workpaper A is used to report those costs associated with providing eligibility outstationing activities within your facility that are directly identifiable.

Part A identifies those direct costs, such as salary and fringe benefits, that are paid by the facility and specific to the employee(s) performing the outstationing activities. The salary costs will automatically transfer to this section after completion of Workpaper B. The fringe benefits costs will be automatically calculated based on Worksheet 1 entries, and will be calculated as the percentage of total benefits to total compensation. All other costs must be calculated and entered by the FQHC.

Part B is to report overhead costs associated with the outstationing activities. Overhead costs will be automatically calculated based on Worksheet 1 entries, and will be calculated as the percentage of total overhead to total costs. All other costs must be calculated and entered by the FQHC.

To verify the reasonableness of the reported outstationing costs, the FQHC must be prepared to provide supporting documentation for all costs claimed if requested by the cost report auditor/contractor. Acceptable supporting documentation might include the following:

- General Ledger, Payroll Vouchers, or Working Trial Balance of Expenses, etc., which would identify salary and fringe benefits and any other direct costs associated with outstationing activities.
- Any internal source documents or workpapers used by the facility to arrive at the claimed outstationing costs such as FTEs, hours, etc.

The final sections determine if the FQHC will be reimbursed for outstationing activities based upon actual cost or based upon the application reimbursement rate. These sections include a calculation of the outstationing reimbursement at the reimbursement rate. The total number of applications automatically transfers from Worksheet B to Worksheet A for this calculation. The current reimbursement rate is \$12.66 per application. The FQHC will be paid the lower of actual outstationing costs or the amount calculated by multiplying the total number of applications by the reimbursement rate. Whichever amount the FQHC is paid for outstationing activities must be adjusted out of the cost report as the FQHC cannot receive a lump sum payment and also have the costs included in the encounter rate calculation. If the actual costs are more than the amount the FQHC is reimbursed for outstationing, the excess costs may remain in the cost report for the encounter rate calculation.

## **Workpaper B-Medicaid Outstationing Salary/FTE Information**

Workpaper B is used to report the specific employees who are performing outstationing activities at the FQHC. The workpaper is designed to assist the FQHC in the calculation of each employee's outstationing FTE and associated salary based upon an estimate of the time involved for one application.

- **Column 1** – Employee last name.
- **Column 2** – Employee first name.
- **Column 3** – Total number of **Medicaid** applications processed by the employee during the reporting period. The total number of **Medicaid** applications for all employees must be equal to the total number of applications on the patient application logs.
- **Column 4** – Average minutes required to assist a patient with an application. This can be an estimate based on history or time studies, and may be different for each FQHC.
- **Column 5** – Total minutes spent on application assistance. Column 3 multiplied by Column 4.
- **Column 6** – Total minutes worked by a full time employee at the FQHC. If the FQHC considers 1,960 hours per year as full time, the full time minutes are 117,600 (1,960 x 60).
- **Column 7** – Calculated application assistance FTE of the employee. Column 5 divided by Column 6.
- **Column 8** – Annual salary of the employee.
- **Column 9** – Application assistance salary cost. Column 7 multiplied by Column 8. The total of this column will automatically transfer to Workpaper A.

Additionally, the FQHC must submit application assistance logs reflecting the eligibility applicant's name, date of application, and social security number if available (see example in Appendix B). The total number of applications processed on Workpaper B, Column C must agree with the number of applications listed on the log.

## **APPENDIX A – FQHC COST REPORT FORMS**

All FQHCs will receive updated electronic versions of these spreadsheets by December 15. Documents included here are **only for reference** and are **not to be submitted**.



**COLORADO MEDICAID FEDERALLY QUALIFIED HEALTH CENTER (FQHC)  
STATISTICAL DATA AND CERTIFICATION FORM**

**1. Cart Report Submission and FQHC Data**

Date Submitted:  
Date Received:  
FQHC Name:  
Street:  
City:  
County:  
State:  
Zip Code:  
Phone Number:  
Fax Number:  
E-mail:

**2. FQHC Facility Numbers**

FQHC Number:

**3. Reporting Period**

Reporting Period Begin:  
Reporting Period End:

**4. Type of Control (Choose one.)**

Voluntary Non-Profit:  
Proprietary:  
Government:  
Other:

**5. Other Federally Qualified Health Centers, Providers of Service including Rural Health Clinics, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Suppliers or Other Entities that are owned or related through Common Ownership or Control to the individual or Entity:**

Clinic or Provider Number

Provider Name, Location

**6. Source of Federal Funds (Choose all that apply.)**

Community Health Center  
(Section 330(4), Public Health Service Act):  
Migrant Health Center  
(Section 329(4), Public Health Service Act):  
Health Services for the Homeless  
(Section 340(4), Public Health Service Act):  
Other:

**7. Medicaid Billing Numbers and Names of Physicians furnishing services at the Federally Qualified Health Center or Under Agreement:**

Physician Medicaid Billing Number

Physician Name

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC**

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cart report prepared by:

for the cart report period listed above in Item 3 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the FQHC in accordance with applicable State rules/instructions except as noted:

Signature (Officer or Administrator of FQHC)

Print Name of Signing Officer or Administrator

Title

Date

**2. (continued from the Statistical Data and Certification Form tab) PHC Facility Numbers**

**PGMC Member:**

7. In addition to the Statistical Data and Certification Form (a) Medical Billing  
Members and Names of Physicians furnishing services at the Federally Qualified Health  
Center or Under Arrangement:

Pharmaceutical Medical Billing Services

Phonetic Name

Example Only. Do Not Use.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES - Worksheet 1, Page 1						FQHC Number: _____			
						Reporting Period Begin: _____			
						Reporting Period End: _____			
						Type of Data: _____			
1	2	3	4	5	6	7	8	9	
Cost Center	Compensation	Fringe Benefits	Purchased & Contract Services	Other	Total (Column 1 through Column 4)	Reclassifications (from tab Worksheet 1 Supplement 1)	Reclassified Trial Balance (Columns 5+6)	Adjustments Increase or (Decrease) (from tab Worksheet 1 Supplement 2)	Net Expenses (Columns 7+8)
<b>A. Covered Health Care Costs</b>									
1. Physicians					0		0		0
2. Interns/Residents					0		0		0
3. Physicians Assistants					0		0		0
4. Nurse Practitioners					0		0		0
5. Nurse Midwife					0		0		0
6. Medical Assistants/Nurse Aides					0		0		0
7. Other Nurses (RN/LPN)					0		0		0
8. Podiatrists					0		0		0
9. Dentists					0		0		0
10. Dental Assistant					0		0		0
11. Dental Hygienists					0		0		0
12. Clinical Social Worker					0		0		0
13. Optometry					0		0		0
14. Psychologist/Psychiatry-Non-BHD					0		0		0
15. Psychologist/Psychiatry-BHD					0		0		0
16. Mental Health Workers-Non-BHD					0		0		0
17. Mental Health Workers-BHD					0		0		0
18. Laboratory-Medical					0		0		0
19. X-Ray-Medical					0		0		0
20. Pharmacy					0		0		0
21. Speech Pathology					0		0		0
22. Occupational Therapy					0		0		0
23. Physical Therapy					0		0		0
24. Vocational Therapy					0		0		0
25. Health Education					0		0		0
26. Medical Records (Admin in OHI)					0		0		0
27. Patient Transportation					0		0		0
28. Durable Medical Equipment (DME)					0		0		0
29. Mailpractice-Physician					0		0		0
30. Medical Supplies					0		0		0
31. Medical and Dental Equipment Repairs & Maintenance					0		0		0
32. Medical and Dental Small Equipment					0		0		0
33. On-Call Services					0		0		0
34. Other (Specify)					0		0		0
35. Other (Specify)					0		0		0
36. Other (Specify)					0		0		0
37. Other (Specify)					0		0		0
38. Other (Specify)					0		0		0
39. Other (Specify)					0		0		0
<b>40. Total Covered Health Care Costs (lines 1-39)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

FQHC

Number: \_\_\_\_\_

Reporting Period Begin: \_\_\_\_\_

Reporting Period End: \_\_\_\_\_

Type of Data: \_\_\_\_\_

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES - Worksheet 1, Page 2

	1. Compensation	2. Fringe Benefits	3. Purchased & Contract Services	4. Other	5. Total (Column 1 through Column 4)	6. Reclassifications (from tab Worksheet 1 Supplement 1)	7. Reclassified Trial Balance (Columns 5+6)	8. Adjustments (Increase or Decrease) (from tab Worksheet 1 Supplement 2)	9. Net Expenses (Columns 7+8)
<b>B. Non-Reimbursable Costs</b>									
41. Education					0		0		0
42. Outreach					0		0		0
43. Community Service					0		0		0
44. Environmental					0		0		0
45. Research					0		0		0
46. Offsite Laboratory(X-Ray/Specialty) Care Office Visits					0		0		0
47. Nurse Home Visitor/Partnership					0		0		0
48. Other (Specify):					0		0		0
49. Other (Specify):					0		0		0
50. Other (Specify):					0		0		0
51. Other (Specify):					0		0		0
<b>52. Total Non-Reimbursable Costs (lines 41-51)</b>	0	0	0	0	0	0	0	0	0
<b>C. Overhead Costs</b>									
53. Administration					0		0		0
54. Financial					0		0		0
55. Marketing					0		0		0
56. Legal					0		0		0
57. Information Technology (IT)					0		0		0
58. Housekeeping					0		0		0
59. Maintenance/Repair					0		0		0
60. Security					0		0		0
61. Supplies					0		0		0
62. Insurance					0		0		0
63. Telephone					0		0		0
64. Utilities					0		0		0
65. Rent					0		0		0
66. Depreciation					0		0		0
67. Amortization					0		0		0
68. Contributions					0		0		0
69. Transportation					0		0		0
70. Mortgage Interest					0		0		0
71. Malpractice-Clinic					0		0		0
72. Property Tax					0		0		0
73. Other (Specify):					0		0		0
74. Other (Specify):					0		0		0
75. Other (Specify):					0		0		0
76. Other (Specify):					0		0		0
77. Other (Specify):					0		0		0
78. Other (Specify):					0		0		0
79. Other (Specify):					0		0		0
<b>80. Total Overhead Costs (lines 53-79)</b>	0	0	0	0	0	0	0	0	0
<b>D. Total Costs (sum of lines A, B, C)</b>	0	0	0	0	0	0	0	0	0



**RECLASSIFICATIONS - Worksheet 1, Supplement 1**

FQHC Number: \_\_\_\_\_

Reporting Period Begin: \_\_\_\_\_

Reporting Period End: \_\_\_\_\_

Type of Data: \_\_\_\_\_

Entry Number	Explanation of Entry	1. Code	2. W/S 1 Cost Center	3. W/S 1 Line Number	4. Amount*	5. W/S 1 Cost Center	6. W/S 1 Line Number	7. Amount*
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36	(sum of column 4 must equal sum of column 7)				0			0

\* Note: Amount must agree to W/S 1, column 6 line, as appropriate.

	<b>FQHC</b>
	<b>Number:</b> _____
	<b>Reporting</b>
	<b>Period Begin:</b> _____
	<b>Reporting</b>
	<b>Period End:</b> _____
	<b>Type of Data:</b> _____

**ADJUSTMENTS TO EXPENSES - Worksheet 1, Supplement 2\***

Explanation of Entry	1. W/S 1 Cost Center	2. W/S 1 Line Number	3. Amount**
1. Offsite Lab/X-Ray/Specialty			
2. Pharmacy			
3. BHO			
4. ACC PMPM-State of Colorado			
5. Outstationing			
6. Lobbying			
7. Marketing			
8. Miscellaneous Income			
9. Interest Income			
10. Lease Income			
11. Physician Hospital			
12. Bad Debt			
13. Fundraising			
14. In-Kind/Donated Costs			
15. Other (Specify):			
16. Other (Specify):			
17. Other (Specify):			
18. Other (Specify):			
19. Other (Specify):			
20. Other (Specify):			
21. Other (Specify):			
22. Other (Specify):			
23. Other (Specify):			
24. Other (Specify):			
25. Other (Specify):			
26. Other (Specify):			
27. Other (Specify):			
28. Other (Specify):			
29. Other (Specify):			
30. Other (Specify):			
31. Other (Specify):			
32. Other (Specify):			
33. Other (Specify):			
34. Other (Specify):			
35. Other (Specify):			
36. Other (Specify):			
37. Other (Specify):			
<b>38. Total Adjustments</b>			<b>0</b>
Total Adjustment per W/S 1			0
Check Figure Should be Zero			0

\* Note: Negative amounts are deducted from Worksheet 1 and positive amounts are added to Worksheet 1.

\*\* Note: Amount must agree to W/S 1, column 8, as appropriate.

FQHC Number:

Reporting

Period Begin:

Reporting

Period End:

Type of Data:

## FQHC PROVIDER STAFF, VISITS AND PRODUCTIVITY - Worksheet 2

### PART A - FQHC PROVIDER STAFF AND LISTS

Position	1. FTE Personnel - Under Agreement	2. FTE Personnel - Staff	3. FTE Personnel - Total	4. Visits - On-Site	5. Visits - Off-Site	6. Visits - Total
1. Physicians			0.00			0
2. Midlevels-defined as:						
2.1 Physician Assistants/Nurse Practitioners			0.00			0
2.2 Certified Nurse Midwives			0.00			0
3. Subtotal	0.00	0.00	0.00	0	0	0
4. Dentists			0.00			0
5. Psychiatrists/Psychologists-Non BHO			0.00			0
6. Mental Health Workers-Non BHO			0.00			0
7. Dental Hygienists			0.00			0
8. Clinical Social Workers			0.00			0
9. Podiatrist			0.00			0
10. Other (Specify):			0.00			0
11. Other (Specify):			0.00			0
12. Other (Specify):			0.00			0
13. Total	0.00	0.00	0.00	0	0	0

### PART B - MINIMUM MEDICAL TEAM PRODUCTIVITY

14. Total Physician and Midlevel Visits (column 6, line 3)		0
15. Total Medical Team FTEs (column 3, line 1 plus 1/2 lines 2.1 and 2.2)		0.00
16. Minimum Medical Team Productivity (line 15 times 4,200)		0
17. Physician and Midlevel Visits to be Used in Rate Determination (greater of line 14 and line 16)		0

### PART C - PROVIDER VISITS FOR RATE DETERMINATION

18. Total Provider Visits Less Physician and Midlevel Visits (column 6, line 13 less column 6, line 3)		0
19. Total Provider Visits for Rate Determination (line 17 plus line 18)		0

FQHC Number: \_\_\_\_\_  
 Reporting \_\_\_\_\_  
 Period Begin: \_\_\_\_\_  
 Reporting \_\_\_\_\_  
 Period End: \_\_\_\_\_  
 Type of Data: \_\_\_\_\_

### DETERMINATION OF FQHC OVERHEAD AND ENCOUNTER RATE - Worksheet 3

Note: No facility input necessary on this page.

#### PART A - DETERMINATION OF OVERHEAD APPLICABLE TO FQHC SERVICES

1. Cost of FQHC Services Excluding Overhead (W/S 1, column 9, line 40)	0
2. Non-Reimbursable FQHC Costs Excluding Overhead (W/S 1, column 9, line 52)	0
3. Cost of All Services Excluding Overhead (sum of line 1 and line 2)	0
4. Percentage of Non-Reimbursable FQHC Costs (line 2 divided by line 3)	#DIV/0!
5. Total Overhead (W/S 1, column 9, line 80)	0
6. Overhead Applicable to Non-Reimbursable FQHC Costs (line 4 times line 5)	#DIV/0!
7. Overhead Applicable to FQHC Services (line 5 less line 6)	#DIV/0!
8. Total Cost of FQHC Services (sum of line 1 and line 7)	#DIV/0!

#### PART B - DETERMINATION OF FQHC RATE

9. Total FQHC Cost (line 8)	#DIV/0!
10. Total FQHC Adjusted Visits (W/S 2, line 19)	0
11. FQHC Current Year Actual Rate per Encounter (line 9 divided by line 10)	#DIV/0!

#### TO BE COMPLETED BY DEPARTMENT

12. FQHC Inflation factor MEI 0.8% [(CMS (CR) #: 8980) times line 11]	#DIV/0!
13. FQHC Current Year Actual Rate per Encounter plus MEI (sum of line 11 and line 12)	#DIV/0!
14. Inflated Base Rate	
15. Alternative Payment Method (lesser of line 13 and line 14)	#DIV/0!
16. Inflated PPS Rate	
17. Encounter Rate (higher of the PPS Rate or the Alternative Payment Rate 8.700.6.C)	#DIV/0!

	FQHC Number: _____
	Reporting Period Begin: _____
	Reporting Period End: _____
	Type of Data: _____

### ENCOUNTER REPORT - Addendum 1

#### ENCOUNTERS

Encounter Type	1. Medicaid Encounters	2. Total Encounters
1. Non-HMO Encounters		
2. HMO Encounters		
3. Total Encounters	0	0

#### MENTAL HEALTH ENCOUNTERS ONLY

Encounter Type	1. Medicaid Encounters	2. Total Encounters
4. Behavioral Health Organization (BHO)		
5. Non-BHO		
6. Total Mental Health Encounters	0	0

#### ENCOUNTER VARIANCE

7. Total Encounters (column 2, line 3)	0
8. Total Encounters (W/S 2, column 6, line 13)	0
9. Variance	0
10. If there is a variance, please explain in the cell below:	

FQHC Number: \_\_\_\_\_  
 Reporting Period Begin: \_\_\_\_\_  
 Reporting Period End: \_\_\_\_\_  
 Type of Data: \_\_\_\_\_

**UNALLOWABLE EXPENSES - Addendum 2**  
**EXAMPLE OF UNALLOWABLE EXPENSE FOR MEDICAID COST REPORTS**

Expense	Yes	No	If Yes, State Amount	General Ledger Account #
1. Alcoholic Beverages				
2. Lobbying Expense-Hospital Association or Other Organizations, including CCHN Dues				
3. Personal Use of Autos				
4. Gifts and Donations				
5. Promotional Items				
6. Sports and Other Tickets				
7. Other Entertainment				
8. Advertising to Increase Patient Utilization				
9. Marketing Salary and Related Costs				
10. Costs Incurred on Behalf of Related Organizations				
11. Fines and Penalties				
12. Country Club Dues				
13. Education Expenses for Spouse or Other Relatives				
14. Cost of Travel Incurred in Connection with Non-patient Care Related Purposes				
15. Costs Associated with Reorganizations, Mergers, Acquisitions, etc.				
16. Miscellaneous Income				
17. Interest Income				
18. Other (Specify):				
<b>19. Total</b>			<b>0</b>	

FQHC  
 Number: \_\_\_\_\_  
 Reporting  
 Period Begin: \_\_\_\_\_  
 Reporting  
 Period End: \_\_\_\_\_  
 Type of Data: \_\_\_\_\_

**MEDICAID OUTSTATIONING ACTIVITY - Workpaper A**

**PART A - DIRECT COSTS PAID BY PROVIDER NUMBER**

Category of Cost	Amount
1. Salary	
2. Fringe Benefits	
3. Travel	
4. Training	
5. Equipment (Specify):	
6. Equipment (Specify):	
7. Equipment (Specify):	
8. Equipment (Specify):	
9. Maintenance of Equipment	
10. Other (Specify):	
11. Other (Specify):	
12. Other (Specify):	
13. Other (Specify):	
<b>14. Total Direct Costs</b>	<b>0</b>
15. Are these costs included in your cost report?	
16. If yes, specify where in the cell below:	

**PART B - OVERHEAD COSTS**

Category of Cost	Amount
17. Housekeeping	
18. Building Maintenance/Repair	
19. Telephone	
20. Utilities	
21. Rent or Building Depreciation	
22. Other Overhead (Specify):	
23. Other Overhead (Specify):	
24. Other Overhead (Specify):	
25. Other Overhead (Specify):	
<b>26. Total Overhead Costs</b>	<b>0</b>
27. Are these costs included in your cost report?	
28. If yes, specify where in the cell below:	

**ADDITIONAL DATA**

29. TOTAL FTE'S PERFORMING OUTSTATIONING	0.00
30. TOTAL NUMBER OF APPLICATIONS PROCESSED (w/FP B, column 3, line 17)	0

**TO BE COMPLETED BY DEPARTMENT**

31. Total Number of Applications Processed (line 30)	0
32. Current Reimbursement Rate per Application	12.66
33. Cost Based on Current Reimbursement Rate per Application	0
34. Actual Application Cost (w/FP B, column 3, line 17)	0
35. Reimbursement Amount (lesser of line 33 and line 34)	0



FQHC Number: \_\_\_\_\_  
 Reporting  
 Period Begin: \_\_\_\_\_  
 Reporting  
 Period End: \_\_\_\_\_

Type of Data: \_\_\_\_\_

**MEDICAID OUTSTATIONING SALARY/FULL TIME EMPLOYEE (FTE) INFORMATION - Worksheet B\***

Entry Number	1. Employee Last Name	2. Employee First Name	3. Applications Processed**	4. Average Minutes per Application	5. Minutes Spent per Application	6. Total Minutes Worked	7. Application Assistance Rate	8. Annual Salary (No Benefits)	9. Application Assistance Cost
1					0		0.00		0
2					0		0.00		0
3					0		0.00		0
4					0		0.00		0
5					0		0.00		0
6					0		0.00		0
7					0		0.00		0
8					0		0.00		0
9					0		0.00		0
10					0		0.00		0
11					0		0.00		0
12					0		0.00		0
13					0		0.00		0
14					0		0.00		0
15					0		0.00		0
16					0		0.00		0
<b>17 Total</b>			<b>0</b>					<b>0</b>	<b>0</b>

Are the salary costs listed above included in your FQHC Medicaid cost report?

\* Note: Provide information on persons directly involved with outstationing activities only.

\*\* Note: Number of applications processed must equal the logs.



## **APPENDIX B – FQHC RATE AND REBASING FORMS**

These documents are provided for reference purposes only. FQHC Rate and Rebasing forms are completed by the state contracted auditor.

<b>FQHC RATE CALCULATION</b>		<b>FQHC #</b>			
<b>PROVIDER NAME</b>					
<b>FYE</b>					
Current Year Costs					
Current Year Visits		=	#DIV/0!		
Current Year Inflation Factor		0.8%	#DIV/0!		
<b>Current Year Calculated Inflated Rate</b>			#DIV/0!		
New Base Rate					
Current Year Inflation Factor		0.8%	0.00		
<b>Current Year Inflated Base Rate</b>			0.00		
<b>(Alternative Payment Method)</b>					
Current Year Calculated Inflated Rate			#DIV/0!		
Inflated Base Rate			0.00		
<b>Lesser of the FQHC current year calculated inflated rate or the inflated base rate</b>			#DIV/0!		
<b>Prior Year</b>					
Prospective Payment System Rate (PPS) Rate					
Current Year Inflation Factor		0.8%		0.00	
<b>Prospective Payment System (PPS) Rate</b>				0.00	
Effective September 1, 2009, the encounter rate shall be the midpoint of the Prospective Payment System (PPS) rate and the alternative rate.					
Prospective Payment System (PPS) Rate			0.00		
Alternative Payment Rate			#DIV/0!		
<b>Midpoint</b>			#DIV/0!		
Effective July 1, 2013 the midpoint is increased by 2% up to the Alternative Payment Methodology					
Midpoint			#DIV/0!		
2% increase			#DIV/0!		
<b>New rate effective</b>			#DIV/0!		
New rate does not exceed APM					

FQHC #:							
FYE:		12/31/2013					
<b>FQHC REBASING CALCULATION</b>							
Provider Name:							
		Inflated to 2012	Inflated to 2013				
FYE	COSTS	0.60%	0.80%			VISITS	
12/31/2011		0	0				
12/31/2012	xxxx		0				
12/31/2013	xxxx	xxxx					
<b>Total Costs</b>		0					
Total Visits = Base Rate		0 =				#DIV/0!	
2014 Inflation Factor		0.8% =				#DIV/0!	
Current Year Inflated Base Rate						#DIV/0!	
Inflated Base Rate		#DIV/0!					
Current Year Calculated Inflated Rate							
Lesser of		#DIV/0!					
<p>The base encounter rate shall be rebased every three years. The new base encounter rate shall be the calculated, inflated weighted average encounter rate, after review for the past three years. 10 C.C.R 2505-10, Section 8.700.7.B.2.b</p>							

## **APPENDIX C – EXAMPLES OF OTHER REQUIRED FORMS**

All FQHCs will receive updated electronic versions of these spreadsheets by December 15. Documents included here are **only for reference** and are **not to be submitted**.

FQHC Name					
General Ledger Trial Balance with Crosswalk					
Date					
FQHC General Ledger			Worksheet 1		
<u>Account Description</u>	<u>acct Balance</u>	<u>Subtotals</u>	<u>Section</u>	<u>Column</u>	<u>Line #</u>
Physician Salaries	\$ 10		A	1	1
Physician Fringe	\$ 10		A	2	1
6360 · Outside Spec.Care Contract	\$ 10		A	3	1
Physician Asst Salaries	\$ 10		A	1	3
Physician Asst Fringe	\$ 10		A	2	3
Med Asst Salaries	\$ 10		A	1	6
Med Asst Fringe	\$ 10		A	2	6
Nurse Salaries	\$ 10		A	1	7
Nurse Fringe	\$ 10		A	2	7
Dentist Salaries	\$ 10		A	1	9
Dentist Fringe	\$ 10				
7240.1 · CME Dental	\$ 10				
7250.1 · Training & Education Dental	\$ 10	\$ 30	A	2	9
6015.2 · Dental Supplies	\$ 10		A	4	9
Dental Hygienist Salaries	\$ 10		A	1	10
Dental Hygienist Fringe	\$ 10		A	2	10
6029 · Contracted Mental Health	\$ 10		A	3	15
6100 · Laboratory Expenses	\$ 10				
6115 · Laboratory Supplies	\$ 10	\$ 20	A	4	17
6240 · Radiology Overreads	\$ 10		A	3	18
6215 · X-Ray Equip & Supplies	\$ 10		A	4	18
6300 · Pharmacy-Clinic Use	\$ 10				
6301 · UMC Dental pharmacy	\$ 10				
6390 · Other Pharmacy	\$ 10				
6305 · Pharmacy contract	\$ 10				
6310 · 340B Pharmacy	\$ 10	\$ 50	A	4	19
Medical Records Salaries	\$ 10		A	1	25
Medical Records Fringe	\$ 10		A	2	25
6401 · Transcription	\$ 10				
6355 · Translation	\$ 10	\$ 20	A	3	29
6102 · Lab Expense- Dental	\$ 10		A	4	30
6045.1 · Dental Equip Rep & Maint	\$ 10				
6050.1 · Dental Equipment	\$ 10	\$ 20	A	4	31
6045 · Medical Equip Rep & Maint	\$ 10				
6050 · Medical Equipment	\$ 10	\$ 20	A	4	32
6060 · Medical Dues & Subscriptions	\$ 10				
6090 · Other Medical Expense	\$ 10	\$ 20	A	4	33
6015 · Medical Supplies	\$ 10		A	4	34
Dental Asst Salaries	\$ 10		A	1	35
Dental Asst Fringe	\$ 10		A	2	35
Eligibility Salaries	\$ 10		A	1	36
Eligibility Fringe	\$ 10		A	2	36
6140 · Outside Laboratory	\$ 10		B	3	45
Administrative Salaries	\$ 10		C	1	51
Administrative Fringe	\$ 10		C	2	51
6514 · Printing, Publications &Postage	\$ 10				
6621 · Facility Interest	\$ 10				
6560 · Dues & Subscriptions	\$ 10				
6560.1 · CCHN Dues & Subscriptions	\$ 10				
6580 · Board Expense	\$ 10				
6585 · Recruitment & Retention	\$ 10				
6590 · Other Administrative Expenses	\$ 10				
Healthy Living Leader Training	\$ 10	\$ 80	C	4	51
Financial Salaries	\$ 10		C	1	52
Financial Fringe	\$ 10		C	2	52

6575 · Accounting, Legal & Consulting	\$	10				
6575.3 · Audit	\$	10	\$ 20	C	3	52
6572 · Community Outreach/Education	\$	10		C	4	53
6575.1 · Legal Expense	\$	10		C	3	54
Data Processing Salaries	\$	10		C	1	55
Data Processing Fringe	\$	10		C	2	55
6525.1 · IT Support	\$	10		C	3	55
6527 · Computer System Maintenance	\$	10		C	4	55
6629 · Janitorial	\$	10		C	3	56
6615 · Maintenance Supplies	\$	10		C	4	56
6645 · Repairs & Maintenance	\$	10		C	4	57
6400 · Medical Records	\$	10				
6515 · Office Supplies	\$	10				
6515.5 · Ink & toner	\$	10	\$ 30	C	4	59
6535 · Insurance	\$	10				
6635 · Facility Insurance	\$	10	\$ 20	C	4	60
6599 · Telephone	\$	10		C	4	61
6617 · Utilities	\$	10		C	4	62
8000 · Depreciation Expense	\$	10		C	4	64
6520 · Travel/Mileage	\$	10				
6520.5 · Travel-Dental	\$	10				
6521 · Meetings	\$	10	\$ 30	C	4	67
6690.1 · Property Taxes	\$	10		C	4	70
6525 · Computer Expense	\$	10				
6526 · Computer Equipment & Supplies	\$	10				
6545 · Office Equipment	\$	10	\$ 30	C	4	71
6511 · Bank Fees	\$	10				
6622 · Laundry	\$	10				
6690 · Other Facility	\$	10	\$ 30	C	4	72
Total Expense per Audit	\$	840				

Sample FTE Report							
FQHC Name							
FTE Report							
Date							
<u>Department</u>	<u>FTE</u>						
Physician	1.00						
Physician Assistant	1.00						
Nurse	1.00						
Medical Assistant	1.00						
Dentist	1.00						
Hygienist	1.00						
Dental Assistant	1.00						
Mental Health	1.00						
Case Manager	1.00						
Eligibility	1.00						
Management	1.00						
Fiscal & Billing	1.00						
IT	1.00						
Facility	1.00						
Support Staff	1.00						
Other-Detail	1.00						
Other-Detail	1.00						
Other-Detail	1.00						
Total	18.00						

## **APPENDIX D – FQHC CHANGE-IN-SCOPE PROCESS**

*Coming soon.*



## APPENDIX E – DEFINITIONS

**Allowable costs:** costs that are reasonable and associated with providing services that are defined in Colorado’s Medicaid State Plan, in the FQHC’s HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#). Allowable costs include those directly or indirectly tied to patient care, and those related to increasing access for the target patient population or informing them of available services.

**Allowable FQHC Provider:** providers who generate an encounter. Limited to: physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker.

**Encounter or Billable Visit:** a one-on-one, face-to-face visit between a FQHC client and Allowable FQHC provider. Group sessions do not generate a billable encounter for any FQHC services.

**Federally Qualified Health Center (FQHC):** an entity which is a recipient of a grant under Section 330 of the Public Health Service Act.

**Fee-for-Service:** billing of Medicaid for covered services not included in the cost report. Reimbursement is at the standard Medicaid fee schedule, not at the FQHC’s encounter rate.

**Incident to:** refers to services and supplies that are an integral, though incidental, part of the physician’s professional service and are: commonly rendered without care or included in the FQHC bill; commonly furnished in an outpatient clinic setting; furnished under the physician’s direct supervision; and furnished by a member of the FQHC staff. Incident to services and supplies include: drugs and biologicals that are not usually self-administered; venipuncture; bandages, gauze, oxygen, and other supplies; or assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician, per the [Medicare Benefit Policy Manual, Chapter 13](#), Section 110.

**Unallowable costs:** costs associated with providing services that are not included in Colorado’s Medicaid State Plan, in the FQHC’s HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#). Unallowable costs include costs associated with self-promotion with the intent of attracting patients who already have a health care home, advertising costs related to fundraising, and costs related to the staff performing those functions.